

Opposition to SB 239
Testimony of Sharon Quick, MD, MA (Bioethics)
President, Physicians for Compassionate Care Education Foundation
Committee on Health and Human Services
Room 2134 of Legislative Building, Carson City, NV
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Chair and members of the Committee:

I am President of the Physicians for Compassionate Care Education Foundation (PCCEF), an organization without religious or political affiliation that promotes safeguarding vulnerable human lives, especially those at the end of life. I have expertise in pediatric anesthesiology, critical care, and medical ethics. As a physician residing in Washington State, where physician-assisted suicide was legalized in 2009, I urge you to oppose SB 239.

Proponents often focus on autonomy rights of patients to opt for hastening death if they want to. However, patient autonomy is limited when decisions harm themselves, others, or society. For example, doctors generally refuse patients' requests for antibiotics for a viral illness because there are no benefits and only risk of side effects and societal harm from resistant organisms. This bill does not give patients new choices or control over their body. Although tragic and ill-advised, anyone can end their life in nonviolent ways without the help of another person with no restrictions whatever on their terminal status, level of "suffering," etc. This bill gives new rights and powers to healthcare professionals, not patients, by creating subjective, error-prone criteria¹ by which they place people into two classes: a protected group (where the standard of care for those who wish to hasten their death is mental health services) or a marginalized group (who can be harmed, as they are not deemed worthy of such protection). Allowing healthcare professionals to devalue some patients undermines the equality of persons which destroys the foundation of law, medical ethics, and autonomy itself.

Healthcare professionals expand their role to judge, jury, and assistant executioner. The prime witness is dead, and the healthcare professional accomplice is given immunity from civil and criminal charges. Financial forces favor death, and the balance of power is shifted away from the patient. With practices where HPs are given incentives to reduce costs or with government-sponsored health plans, healthcare professionals and/or government have conflicting goals—the primary responsibility to protect the weak and vulnerable is challenged by the enticement of killing them to save money. Barbara Wagner, for example, received a letter from the Oregon Health Plan refusing to pay for a chemotherapy agent to extend her life but offering physician-assisted suicide as one of her options.²

The so-called "safeguards" have not prevented documented instances of physician noncompliance, coercion,³ inappropriate selection,⁴ botched attempts,⁵ and active euthanasia.⁶ Oversight of this process of lethal drug prescription is minimal, without any qualitative review as would be required in a hospital setting. The OR Health Division admitted in a report about the required documentation submitted by physicians prescribing lethal drugs: "For that matter, the entire account [submitted by the physicians] could have been a cock-and-bull story... we cannot detect or accurately comment on issues that may be under reported."⁷ Enforcement of compliance in submitting forms is non-existent in Washington. Hundreds of forms are missing from physicians and for patient consent, yet nothing is done. In Oregon, patients are getting lethal prescriptions for diagnoses of anorexia, hernia, and arthritis—diagnoses that are not terminal by themselves—but there is no process for challenging physician actions. In spite of the high incidence of depression in the terminally ill which may be overlooked by up to 40 percent of physicians, less than 5 percent of patients in WA and OR are referred for mental health evaluation before getting a lethal prescription. Evidence indicates that depressed patients are inappropriately getting lethal drugs.⁸ In 2012 17% of all patients given lethal drugs lived longer than 6 months, with a maximum of over 3 years. How many patients might have lived longer if they had not taken lethal drugs is unknown. Physician prognosis is unreliable. Since 2019, WA has now stopped reporting complications, survival time, and several other types of data that used to be recorded. Because no evaluation of patient capacity must be done when patients actually take the lethal drugs and no one is required to be present, it is unknown if patients are ingesting drugs after they have lost capacity or how often a greedy heir might hurry death along in a frail, vulnerable patient.

Unfortunately, tired caregivers or family sometimes express a desire to deny routine care to sick patients (with months or years of life remaining) to end their burden, not that of the sick patient.⁹

Wherever physician-assisted suicide has been legalized, the subjective criteria are changed, allowing expanding numbers of people to be classified into the marginalized group.¹⁰ Oregon changed their law in 2019 to allow the waiting periods (15 days or 48 hours) to be eliminated if a patient is expected to die within that time period. SB239 has the same provision (Sec.24.1). One study found that “even when patients are in the terminal phase and close to death, clinicians are not very good at predicting how much longer they will survive.”¹¹ The only way to determine that a patient is within days of death is that there are signs of organ dysfunction. The first two systems to decline are usually the brain and the ability to ingest liquids. By the time one knows a patient is near death the chance of obtaining a valid consent is virtually nil, and it is unlikely that the patient could ingest the lethal concoction. Patients are more likely to die choking on their vomit. If a patient is already in the process of dying because death is within a few days, lethal drugs are unnecessary, and would be contraindicated. Oregon’s new law requires only one physician, with no requirement for expertise in palliative care or terminal illness and without a second opinion, to make this complex prognosis that can result in death the same day as all three requests. The change in Oregon’s law is medically unethical and contraindicated.

Oregon’s 2021 Report¹² states that 81 patients (21% of the lethal drug recipients) were exempted from one of the waiting periods because they were close to death. Since a prognosis of near death cannot be given until there are signs of organ dysfunction (usually declining brain function and inability to swallow liquids), the likely possibilities for these patients are (1) that the physician was wrong in prognosis and the patient was farther from death so that decision-making capacity was intact, or (2) the vulnerability and compromised condition of a patient close to death was taken advantage of to get an invalid consent for lethal drugs. In both situations the law was violated, and patients mistreated. Nothing has been done by the Oregon Health Authority to stop this abuse. In a recent Oregon Senate Judiciary Committee meeting, one of the physicians testifying in favor of yet another bill to remove more safeguards, stated that many of the evaluations of patients requesting lethal drugs (especially those in rural areas) are now done virtually without ever seeing patients. How can this prevent coercion?

Physician-assisted suicide creates distrust between patients and physicians and among physicians themselves. Studies show that physicians view persons with disabilities as having a lower quality of life than those persons do themselves, and the terminally ill often develop disabilities.¹³ Doctors’ biases can influence a terminally ill patient toward requesting a hastened death.¹⁴ Some patients with serious illnesses in the northwest are beginning to fear physicians’ motives, as they are unsure who are the death doctors and whether their options are portrayed as more bleak than they are. They want multiple opinions to ensure they are not being abandoned as a hopeless cause. Patients can be demoralized when physicians offer them lethal drugs, because it indicates that the physician does not value the patient’s life. Physicians are increasingly distrustful of referring patients to colleagues, when some have had patients with depression inappropriately, and over their objections, killed by their colleagues’ lethal prescriptions.¹⁵ This bill fractures the physician-patient alliance and destroys the foundation of medical ethics.

Pain or inadequate symptom management should never be a reason for terminally ill patients to seek lethal drugs. Even a physician who advocates for lethal drug prescriptions admits this.¹⁶ Testimonies about patients with excessive pain or other symptoms at the end of life indicate that these patients had inappropriate palliative care. One patient was told by his doctors said he was “maxed out on morphine,” and lethal drugs were his only alternative.¹⁷ However, there is no “maximum” for morphine in terminally ill patients. Most patients do not have intolerable pain as they approach death, and in the rare situation where various analgesics, nerve blocks, and other treatments are not sufficient, temporary sedation can be used to relieve pain. That patient’s doctor failed him. Studies show that doctors may lack knowledge about palliative care possibilities.¹⁸⁻²⁰ Rather than removing safeguards to obtain lethal drugs, we should ensure that patients have access to good palliative care and physicians are not deficient in their use if it.

Patients’ access to palliative care should not be taken as a given, as there is evidence that minorities, the uninsured, those on Medicaid, and those living in disadvantaged communities may encounter barriers to receiving palliative care.²¹ It would be a tragedy for these populations if this bill made lethal prescriptions more accessible than palliative care.

Most dying patients are comfortable and do not seek lethal drugs because of pain. A wish to die might really mean “I’m afraid I’m a useless burden.” Often this is a plea for help and assurance of their value, not a desire to kill themselves.²² Despite developing disabilities, the terminally ill, if given sufficient time and support to adjust, often overcome despair to have meaningful experiences in the last months or even hours of their lives. A physician’s role is to value a patient’s inherent, unchanging dignity, no matter what that person’s condition or social situation. This benevolent responsibility turns malevolent when physicians supply lethal drugs to patients—who may be in a vulnerable period of temporary despair. Offering lethal drugs to despondent patients implies agreement that their loss of function or disability makes their lives expendable and not worth living. Because physician-assisted suicide is a condemnation of patients with disabilities, the National Council on Disability and many disability organizations oppose it.²³

Autonomy has two parts: a right to make choices and the capacity to make choices. The terminally ill are vulnerable with a high likelihood of a compromised capacity to choose due to a myriad of complex circumstances. They have good and bad days, fluctuating and progressively declining decision-making capacity, grief, pain, depression, external pressures, changing relationships, etc. In one study of cancer patients, 90% had deficits in some subscale measurement of decision-making capacity, and physicians did not readily recognize these impairments.²⁴ Depression is common and treatable in the terminally ill, and it may manifest as a desire for a hastened death; it often goes unrecognized and untreated by physicians. In one study, only 6% of psychiatrists were “very confident” that they could “adequately assess whether a psychiatric disorder was impairing the judgment of a patient requesting assisted suicide.”²⁵ Many psychiatrists feel that specialized forensic psychiatrists may be needed to determine a terminally ill patient’s decision-making capacity.²⁶ If a patient’s wishes are acted upon at face value, without recognizing underlying deficiencies in a person’s capacity to choose, that person’s autonomy has been violated. Patients need love and care from family and health care professionals, not cold abandonment to a lethal prescription.

One terminally ill man requested lethal drugs because he didn’t want his mom to care for his personal hygiene. However, his doctor worked with him to find a solution and he no longer wanted lethal drugs. Vulnerable patients often make rash decisions out of fear, depression, embarrassment, subtle pressure by a tired caregiver who makes them feel like a burden, or other reversible concerns. Sorting through the reasons behind a patient’s request for lethal drugs—is it pain (unusual, but it can be controlled), depression (medicines take two weeks to begin to work, longer for full effect²⁷), reversible or transient emotional issues (coming to terms with losses, new disabilities, or overcoming embarrassment), feeling alienated from or devalued by family, etc.—takes time and compassionate, knowledgeable physicians who should never be tempted by the option to abandon vulnerable patients to their fears under a guise of autonomy by prescribing lethal drugs.

Families and friends may be uninformed about normal aspects of the dying process and transfer their feelings of revulsion about patient disabilities or inadequacies as complaints that their loved one is “suffering.” Some aspects of “suffering” seem to bother family members more than they could have bothered the patient. For example, patients are not usually aware or bothered by coma, but family sometimes labels a patient in a coma as “suffering.” Family members do not like to see loved ones declining and losing function. Sometimes they transfer their own idea that they would not want to be like that to the patient and assume he/she would feel the same way—that the patient would rather be dead than disabled. Patients may sense when those around them are bothered by their appearance or disabilities, and this can contribute to making them feel like a burden and push them toward asking for lethal drugs. If patients are supported wholeheartedly through the onset and progression of disability, they often come to terms with their dysfunction and find renewed meaning in living (even when terminal). Lethal drugs are not a substitution for family education and support—which take time.

Unacceptably high rates of overdoses and suicides are a concern. Studies have shown that legalization of physician-assisted suicide leads to an increase in total suicides²⁸ suggesting an increased inclination for people who are not terminally ill to commit suicide.²⁹ Non-physician-assisted suicide rates in Washington have increased 30 percent since 2008 when I-1000 passed to legalize physician-assisted suicide, and the rate is 20 percent higher than the national average.³⁰ Legalization of physician-assisted suicide may contribute to increasing suicide contagion.

Commentary on the bill by Section:

Page 4: The statement that “patients with a terminal illness may undergo unremitting pain, agonizing discomfort, and a sudden, continuing and irreversible reduction in their quality of life” happens to people in all parts of life, whether terminally ill or not. As an anesthesiologist, I can assure you that no dying patient should ever have intolerable pain. Pain in dying patients is much easier to treat than chronic pain because one does not need to be concerned about narcotic addiction. Unfortunately, I hear testimonies from families about patients who were in pain and use this as an excuse to push for lethal drugs or shortening a waiting period. Sometimes the testimonies are about patients who are in a chronic stage of illness—not terminal—so they would not actually be eligible for lethal drugs. Testimonies about dying patients in pain mean that the doctors lack knowledge. One testimony was about a cancer patient who had been told by his doctor that he was “maxed out on morphine” and his only alternative was lethal drugs. If this is what was really said, that doctor did not know what he was doing. There is no maximum on morphine for terminally ill patients. It should be titrated to effect. Studies have shown that doctors are not always aware of all the palliative care possibilities and/or may not know when to refer to pain management specialists (anesthesiologists with specialty in pain management). This latter specialty has expertise in using multiple types of pain medicines and can do a variety of procedures that may help with pain relief—such as nerve blocks, epidurals, and even procedures like ablation of the nerves to the pancreas for someone with pancreatic cancer (stops pain impulses from the pancreas). Lethal drugs should never be a solution for inadequate symptom management by physicians. Even Lonny Shavelson, a well-known doctor who advocates for prescribing lethal drugs, agrees with this statement in his book.³¹ Lethal drugs for patients are a poor solution for lack of education of their doctors, and they are unnecessary for and antithetical to palliative care.

People who develop disabilities at any stage of life, including when terminally ill, are often seen by doctors as having a poor quality of life. However, patients in a state of depression, hopelessness, or distress over a new disability often adjust to their circumstances and find new meaning and purpose and see their own quality of life as better than their doctors evaluate it. The terminally ill also can make this transition if they are given time and support to allow their perspective to change.

This bill prevents a coroner from certifying the cause of death or investigating the death of a patient who dies after self-administering lethal drugs (**Sec. 3**). Given that (1) there is no independent verification (such as by a notary) of the validity and lack of coercion of the patient’s signature and the identity of the witness, (2) in states such as OR both physicians are completing patient evaluations completely by virtual means, even when the law states they are to “examine”, (3) there is no requirement that a neutral party be present when the patient ingests lethal drugs, (4) patient decision-making capacity fluctuates and progressively declines, the provisions in this bill are a perfect set-up for elder abuse and homicide by a greedy heir. Yet a coroner is prevented from making such an investigation.

It requires falsifying the death certificate by naming the terminal disease as the primary cause of death (**Sec. 4**), when in actuality an overdose of lethal medications is the primary cause of death. This forces health care professionals to lie and skews medical research studying illnesses by shortening life expectancies for that disease.

Sec. 13 uses the incorrect term “competent” which is a legal term for a judge to decide whether or not a patient needs a guardian. “Decision-making capacity” (capacity) is determined by physicians. Unlike competence, capacity can fluctuate and varying degrees are possible. A patient may have capacity to decide what clothes to wear but may not have capacity to make a decision about a risky surgery. Greater degrees of capacity are required for procedures that have higher risk. For a decision that results in irreversible and potentially immediate death, the highest level capacity is required. The capacity to choose can be affected by cognitive ability (which fluctuates and declines progressively in the terminally ill), psychological or psychiatric conditions such as anxiety or depression, coercion, grief, etc.

Sec. 17: NRS 433.209 defines a “person professionally qualified in the field of psychiatric mental health” as including licensed psychiatrists, psychologists, clinical social workers with master’s degrees, registered nurse with a master’s degree in psychiatric nursing, a marriage and family therapist, or a clinical professional counselor. In one study, only 6% of psychiatrists were “very confident” that they could “adequately assess whether a psychiatric disorder was impairing the judgment of a patient requesting assisted suicide.”²⁵ Many psychiatrists feel that specialized forensic psychiatrists may be needed to determine a terminally ill patient’s decision-making capacity.²⁶ This bill’s allowance of underqualified

people to make the serious determination of capacity that may result in a patient's death demonstrates disregard for the vulnerability of terminally ill patients and the complexity of such a diagnosis.

Sec. 22: Physicians cannot reliably determine that a person will die in 6 months. Prognoses are in terms of percent survival in a specified time frame, such as 5% in 5 years. Even with such a poor prognosis, 5 out of 100 patients will still be living after 5 years. There will always be those who are expected to die but do not. Sometimes a new treatment can develop that extends the life of people who are thought to be months from death. For example, there is an ongoing clinical trial of a new drug that is also being provided on a compassionate use basis (for those who have no other options). One man with a brain tumor who was blinded by the tumor and declining, had his blindness reversed and progression of the tumor slowed by this new drug.

Sec. 24.a. : Attending practitioner can waive the waiting period if the patient is expected to die within 15 days. A prediction that a patient is close to death only occurs when patients' organ systems are already beginning to shut down—that is, death is not some future event, but is already in process. Lethal drugs are not only unnecessary during the dying process, but likely contraindicated the closer a patient is to death. The first organ systems to decline are usually the brain and the ability to ingest liquids. Roughly half of patients will have decreased brain function prior to 7 days from death and the other half within 7 days from death. Within 3 days of death 90% of patients have compromised brain function. It is difficult to predict when a patient will die, and specialists are frequently wrong in their prognosis. Allowing one non-physician without specialization and without a second opinion to assess prognosis and decision-making capacity and provide immediate lethal drugs demonstrates reckless disregard for the complexity and dangers of this situation. Misjudgment could result in serious complications such as a patient dying from choking and aspirating their vomit.

Sec. 24. B.: Only one witness that the patient is acting voluntarily is necessary. There is no requirement for independent verification (such as by a notary) of the validity and lack of coercion of the patient's signature and the identity of the witness. This is a set-up for elder abuse and coercion.

Sec. 36 "A person shall not prevent a patient from making or revoking or require a patient to make or revoke a request for medication that is designed to end the life of the patient as a condition of receiving health care." Consequences are not named for not abiding by this regulation. Would a physician trying to counsel a patient not to take lethal drugs, and for reason of conscience, not being able to provide further care, be subject to a lawsuit? A family member who declines to take a patient to see a doctor because one of the purposes of the visit is to get a lethal prescription can be sued?

Sec. 37. 2., 3. Requires acts that violate conscience of physicians unwilling to participate: referral and documenting the first request (makes the physician a participant).

Sec. 39. Health care facility or provider of health care that for reasons of conscience do not want to participate in the act cannot allow information promoting lethal prescriptions to be given to patients, but this act forbids such employers from doing this or enacting consequences for such action. This is a conscience violation.

References

1. For example, prognoses of life expectancy are guesses. Some will live beyond what is expected even with low survival rates such as 5% in 5 years. Inaccurate prognoses are documented in states that have legalized physician-assisted suicide, with some patients living years beyond the 6-month prediction. For example, in 2012 in WA, 17% of patients lived 25 weeks or more, with a maximum time of 150 weeks—over 3 years. How many of the patients who took lethal drugs might have lived longer is unknown. Washington State Department of Health. 2013 Death with Dignity Act Report. 2014. chrome-extension://efaidnbmninnbpcajpcgclclefindmkaj/<https://doh.wa.gov/sites/default/files/legacy/Documents/Pubs/422-109-DeathWithDignityAct2013.pdf?uid=63faaaafe406d>
2. Christie T. A gift of treatment: When the Oregon Health Plan fails to cover a cancer drug, the drugmaker steps in. The Register-Guard. 2008 June 3;Sect. 1A.
3. Kate Cheney was denied a lethal prescription twice because of dementia and concern that Kate's daughter was the driving force behind her request. Kate's daughter took her doctor shopping until lethal drugs were prescribed. Kate died by lethal ingestion. Barnett, Erin Hoover. "Physician-assisted suicide: A family struggles with the question of whether mom is capable of choosing to die." The Oregonian. January 9, 2019.

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